Applicant Information

You may review the content of the application here. It is best to complete each response fully before you proceed to the next response. In addition, it may aid in the preparation of your application to prepare the following before you continue.

- a **current** resumé or *curriculum vitae* in PDF file format. Attach a page that specifically abstracts the following:
  - Briefly **summarize your employment history** including the number of years that you have been employed at the organization from which you are applying and the number of years of clinical or non-clinical employment in any organization serving rural or underserved persons.
  - Briefly **summarize clinical and non-clinical volunteer experiences** with any organization or project associated with rural or underserved persons.
  - Briefly **summarize your principal clinical activities associated with primary care access or primary care delivery to rural or underserved persons over the last 5 years**. This summary should be relevant to your professional licensure and may include but is not limited to: clinics, residency, rural track, internships, preceptorships, attending, surgical, consultation, supervision, counseling or outreach.
  - Briefly **summarize any graduate or undergraduate research or scholarly activities associated with primary care access or primary care delivery for rural or underserved persons**. This summary should be relevant to your professional licensure and may include but is not limited to dissertation, thesis, published works, conferences, faculty or precepting.
- **current** loan statements from each of your lenders in PDF file format
- a personal statement of up to 5000 characters, including spaces, that includes:
  - personal background, such as whether your grew up in an underserved and/or rural community
  - personal commitment to practice in a health professional shortage area and/or care for under served patients
  - Your path to a career in a health profession
  - Your education and training (include projects and skills related to serving under served people)

- The patient population to which you provide services and a description of how you, as a health care provider, will address the disparities and/or improve the health outcomes of this specific patient population (*e.g.*, community outreach/education, support groups, research, etc.)
- Your plans for practice once your loan repayment service obligation is complete

You will be asked to provide contact information for your clinical supervisor and a senior manager at your practice. You may want to contact them in advance.

It is best to complete each response fully before you proceed to the next response. It may aid in the preparation of your application to prepare **current** loan statements from each of your lenders in PDF file format.

Enter your full legal name

First

Middle

Last

Enter your date of birth (mm/dd/yyyy)

Optional demographic questions
your responses in this section are not used in the selection of awards

What is your gender?

What is your race?

- [ ] American Indian or Alaska Native
- [ ] Asian

- [ ] Black or African American
- [ ] Native Hawaiian or other Pacific Islander
- [ ] White
- [ ] Other

What is your ethnicity?

Enter your primary personal contact information
do not enter a Post Office box for address

Address

City

State

Zip

Phone contact information

Primary

Alternate

Work email address

Enter your Social Security number
format: ###-##-####

Your Social Security number is required for state contracting purposes. Data is collected and stored in a secure, encrypted format.

Employer

Enter the full legal name of your employer

Enter your hire date for your current clinical position with this employer (mm/dd/yyyy)

Enter your physical practice location

Clinic site name (if applicable)	
Physical address	
City	
Zip code	
Average **clinical hours** per week at this site	

Enter contact information for your Human Resources manager

If your organization does not have a HR manager, enter information for the CEO, executive director, or superintendent

First name	
Last name	
Phone number	
Email	

In a typical week, are you routinely scheduled to practice at any other clinic site, with any other employer, or in any other specialty (*e.g.*, emergency medicine)?

- Yes
- No

Describe the nature of your other practice time

Do you attend in a hospital in addition to your outpatient practice following up with **your own patients**?

- Yes
- No

How many hours per week do you spend **following up with your own patients** at the hospital?

Debts

Education Loan Debt Information

Qualifying education loan debt includes government and commercial loans for actual costs of educational and living expenses related to your undergraduate and graduate education. Qualifying debt must be associated with a degree in the health profession in which you will satisfy your service obligation.

Educational loan debt associated with other post-secondary degrees, unrelated to your health professional degree, is ineligible for loan repayment under this program. These loans should not be entered below. Primary Care Loans issued by the federal Health Resources and Services Administration are not eligible for loan repayment under this program.

Enter the full name(s) of each of your education loan lenders/servicing companies. If you have more than one loan with a lender or servicer, you need only list that lender or servicer once below.

Lender 1		0 loan balance
Lender 2		0 loan balance
Lender 3		0 loan balance
Lender 4		0 loan balance
Lender 5		0 loan balance
Lender 6		0 loan balance
Lender 7		0 loan balance
Lender 8		0 loan balance
Total		0 loan balance

Upload a current loan statement from each lender you listed on the previous page. Each document may take up to 30 seconds to load. Documents must be in PDF format and titled in the following way LASTNAME-LENDER. For example:

SMITH-NELNET.pdf
SMITH-SOFI.pdf

The uploaded statement(s) should clearly display your name, the lender's complete contact information, the outstanding loan balance, and the loan payment status listed as "paid current". Do not upload reports from the National Student Loan Data System (NSLDS) or a personal credit report.

Submit

Application Notice

Your application will only be reviewed if it is complete and received by the published deadline. A complete application includes all required supporting documentation and two letters of support.

By signing on the next page, you attest that all statements contained in the application are true and accurate to the best of your knowledge. Any material false statement may disqualify you from consideration in the current and any future award cycle. Should a material false statement be discovered after an award is made, your contract may be in default, which could result in significant financial penalties.

By submitting this application, you are authorizing representatives of the Primary Care Office at the Colorado Department of Public Health and Environment to contact your educational institutions, employers, supervisors, professional licensing boards, lenders, and those who wrote letters of support on your behalf to verify the information contained in your application. By submitting this application, you also authorize the Primary Care Office to conduct a general background check.

If you are selected for an award from this program, you will enter into a minimum 36-month contract with the state of Colorado that will require continuous practice at an eligible practice site. Your contract will require that you maintain all attributes of your practice that make you eligible to receive an award throughout your term of service. Failure to do so may cause a contract default, which could result in significant financial penalties.

- ○ I wish to **submit** my application
- ○ I wish to **withdraw** my application

Application Signature

Use your mouse or track pad to create a signature in the cell below. Please use care to assure that it is legible and recognizable as your signature.

Clear

Application Feedback

Optional application feedback

your responses in this section are not used in the selection of awards

How difficult was it to complete this application?

Extremely easy	Somewhat easy	Neither easy nor difficult	Somewhat difficult	Extremely difficult
○	○	○	○	○

Comments or other feedback about the application process

How did you hear about the Colorado Health Service Corps?

- [ ] Colleague
- [ ] Employer
- [ ] Federal web site
- [ ] News media
- [ ] Professional association
- [ ] Social Media (e.g., Facebook, Twitter)
- [ ] State web site (e.g., www.coloradohealthservicecorps.org)
- [ ] Other

Training

Professional training experiences

	Yes	No
Did you graduate from a health professional degree program in Colorado?	○	○
Did you participate in a rural track while you were in school?	○	○
Did you participate in a community health track while you were in school?	○	○
Did you graduate from a medical residency program in Colorado?	○	○

Colorado degree program information

School

City

Completion Date (mm/dd/yyyy)

Rural track or emphasis program information

School

Track

Completion Date (mm/dd/yyyy)

Community health track or emphasis program information

School

Track

Completion Date (mm/dd/yyyy)

Colorado residency program information

Residency name

City

Supervisor

Completion date (mm/dd/yyyy)

Do you have other post secondary degrees **unrelated** to your clinical professional training?
exclude bachelors or prerequisite degrees for your professional degree

- Yes
- No

List post secondary degrees unrelated to your clinical professional degree

	Degree (bachelors, masters, doctorate)	Study major	Completion date
1			
2			
3			
4			
5			

Can you provide clinical services in a language other than English?

- Yes
- No

List language one spoken with proficiency in a clinical context

Proficiency level of language one

- Elementary Proficiency
-

Limited Working Proficiency

- General Professional Proficiency
- Advanced Professional Proficiency
- Functionally Native Proficiency

List language two spoken with proficiency in a clinical context

Proficiency level of language two

- Elementary Proficiency
- Limited Working Proficiency
- General Professional Proficiency
- Advanced Professional Proficiency
- Functionally Native Proficiency

List language spoken with proficiency in a clinical context

Proficiency level of language three

- Elementary Proficiency
- Limited Working Proficiency
- General Professional Proficiency
- Advanced Professional Proficiency
- Functionally Native Proficiency

Service Requirement

Select your preferred service obligation hourly requirement. All contract terms are for a period of three years.
clinical practice hour definitions

- Full time
- Part time

Do you regularly practice at least 40 professional hours per week that includes at least **32 hours in direct clinical care** with patients?

Direct clinical care is defined as a medically necessary medical, dental, mental or behavioral health visit or a qualified preventive health visit. The visit **must be a face-to-face (one-on-one) encounter between the patient and clinician** during which time one or more services are rendered. Care rendered via **telemedicine is not currently eligible** to achieve the 32 hours of direct care minimum.

- Yes
- No

Do you regularly practice at least 20 professional hours per week that includes at least **16 hours in direct clinical care** with patients?

Direct clinical care is defined as a medically necessary medical, dental, mental or behavioral health visit or a qualified preventive health visit. The visit **must be a face-to-face (one-on-one) encounter between the patient and clinician** during which time one or more services are rendered. Care rendered via **telemedicine is not currently eligible** to achieve the 32 hours of direct care minimum.

This election may be appropriate for clinicians who work full time but have supervisory, administrative or consultative responsibilities that result in clinical contact hours of between 16 and 32 hours in a typical work week.

- Yes
- No

Practice Incentives

Have you ever participated in a program that provided a specific monetary, tuition or other benefit in exchange for a period of employed clinical service?

-

Yes

No

Which practice incentive program(s) have you participated in?

	Yes	No
Colorado Health Service Corps		
Employer paid signing bonus		
Employer paid tuition and/or training		
Federal Primary Care Loan		
Indian Health Service		
National Health Service Corps		
Scholarship with future service obligation		
Other		

When does/did your service obligation end?
mm/dd/yyyy

Colorado Health Service Corps	
Employer paid signing bonus	
Employer paid tuition and/or training	
Federal Primary Care Loan	
Indian Health Service	
National Health Service Corps	
Scholarship with future service obligation	
${q://QID33/ChoiceTextEntryValue/7}	

Reference

Upload a current resumé or *curriculum vitae*. The document may take up to 30 seconds to load. The document must be in PDF format and titled in the following way LASTNAME-RESUME.pdf or LASTNAME-CV.pdf

Remember to attach a page that specifically abstracts the following:

- Briefly **summarize your employment history** including the number of years that you have been employed at the organization from which you are applying and the number of years of clinical or non-clinical employment in any organization serving rural or underserved communities or populations.
- Briefly **summarize clinical and non-clinical volunteer experiences** with any organization or project associated with rural or underserved populations.
- Briefly **summarize your principal clinical activities associated with primary care access or primary care delivery to rural or underserved populations over the last 5 years**. This summary should be relevant to your professional licensure and may include but is not limited to: clinics, residency, rural track, internships, preceptorships, attending, surgical, consultation, supervision, counseling or outreach.
- Briefly **summarize any graduate or undergraduate research or scholarly activities associated with primary care access or primary care delivery for rural or underserved populations**. This summary should be relevant to your professional licensure and may include but is not limited to: dissertation, thesis, published works, conferences, faculty or precepting.

Personal Statement

Enter a personal statement describing your interest in and commitment to serving the under served people of the community where you practice. Your essay limit is 5000 characters including spaces. Please clearly address each of the following:

- Your personal background, such as whether your grew up in an under served and/or rural community
- Your personal commitment to practice in a health professional shortage area and/or care for under served patients
- Your path to a career in a health profession
- Your education and training (include projects and skills related to serving under served people)
- The patient population to which you provide services and a description of how you, as a health care provider, will address the disparities and/or improve the health

outcomes of this specific patient population (e.g., community outreach/education, support groups, research, etc.)
- Your plans for practice once your loan repayment service obligation is complete

References

Enter contact information for two people who can provide a reference for your application. **One reference must be provided by your direct supervisor. The other can come from someone who is in a position to evaluate your clinical skills and has the authority to speak on behalf of your organization.** Some examples include:

- Chief clinical officer
- Executive director or chief executive officer
- Clinic, practice, or program manager
- Human resources manager

If you have been working at your current site for less than six months, you may request a reference from a previous employer, faculty member from your health professional training program, or supervisor during a clinical rotation in a rural or under served location.

Each person you list below will receive an email from this application system prompting them to complete a confidential on-line form, which will become part of your application. We strongly recommend that you follow up with your listed

references to assure that they received the email prompting their reference. If they did not receive an invitation email, you may share the following link with them.

https://coloradopco.co1.qualtrics.com/SE/?SID=SV_5mx7ipCqG0LFLaB

If reference statements are not received when the application closes, your application will not be complete.

Reference: direct supervisor

First Name	
Last Name	
Email	

Reference: other organization official

First Name	
Last Name	
Email	

References

Enter contact information for two people who will write a letter of support for your application. **One letter must be provided by your residency director. The other can come from someone who is in a position to evaluate your clinical skills.**

Each person you list below will receive an email from this application system prompting them to complete a confidential on-line form, which will become part of your application. We strongly recommend that you follow up with your listed references to assure that they received the email prompting their letter of support. If they did not receive an invitation email, you may share the following link with them.

https://coloradopco.co1.qualtrics.com/SE/?SID=SV_8wWNIJUzBfnSV49

If letters of support are not received when the application closes, your application will not be complete.

Reference: residency director

First Name

Last Name

Email

Reference: other

First Name

Last Name

Email